MR #:
Patient Name:

OSR PHYSICAL THERAPY PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

Mailing Address:

Phone Numbers: **OK To Call** **Best Time To Call**

Home: ☐

Work: ☐

Cell: ☐

May we send you text messages for your appointment reminders to the number(s) listed above? ☐ Yes ☐ No

May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email:

Preferred language: **Interpreter required?** ☐ Yes

Date of Injury: **Referring Physician:**

Injury Area: **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

State Where Accident Occured:

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: **Occupation:**

Address:

Phone:

Employer: **Occupation:**

Address:

Phone:

INSURANCE INFORMATION

Primary Insurance:

Policy Holder's Name: **Holder's Birth Date:**

Policy or Certificate #: **Group #:**

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name: **Holder's Birth Date:**

Policy or Certificate #: **Group #:**

Policy Holder's Employer:

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other

Specify if other :

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name Relationship

Name Relationship

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: OSR PHYSICAL THERAPY

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:** _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:** _____

LIABILITY

I know and agree that: OSR PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. **Initials:** _____

WAIVER AND RELEASE

I hereby release, discharge and acquit: OSR PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:** _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: OSR PHYSICAL THERAPY
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:** _____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials:** _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:** _____
I acknowledge receipt of the Statement of Patient Rights. **Initials:** _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

Medical History Form

Patient Name:	**Today's Date:**	
Referring Physician:	**Date of Birth:**	**Age:**
Primary Care Physician:	**Date of Injury or Onset:**	
Date of Next Physician Appointment:		

Reason for Therapy:

Cause of Injury or Onset: ☐ Accident ☐ Auto ☐ Work ☐ Other: **If Other, please explain**:

Have you been hospitalized for the present condition? ☐ Yes ☐ No **If Yes, date**:

Did you have surgery for this condition? ☐ Yes ☐ No **If Yes, date**:
If Yes, surgery type:

Are you currently receiving any other care for the condition mentioned above? ☐Yes ☐No
If Yes, please describe:

Have you ever received therapy in the past for the condition mentioned above? ☐Yes ☐ No **If Yes, date:**
Describe previous treatment:

Previous Treatment: ☐Successful ☐Unsuccessful

Have you fallen in the last year? ☐ Yes ☐ No **If Yes, how many times?** **If Yes, were you injured?** ☐ Yes ☐ No
Do you feel unsteady when standing or walking? ☐ Yes ☐ No **Do you worry about falling?** ☐ Yes ☐ No

What are your personal goals/outcomes you hope to achieve from therapy?

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	**Do you smoke or use tobacco?** ☐ Yes ☐ No

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

☐ **Allergies** ☐ **Latex** ☐ **Other**	☐ **Dizziness**	☐ **Kidney Problems**
☐ **Anemia**	☐ **Epilepsy or Seizure Disorder**	☐ **Metal Implants**
☐ **Anxiety or Panic Disorders**	☐ **Fainting**	☐ **MRSA**
☐ **Arthritis** ☐ **OA** ☐ **RA**	☐ **Fatigue or Weakness**	☐ **Multiple Sclerosis**
☐ **Asthma**	☐ **Fever or Chills**	☐ **Nausea / Vomiting**
☐ **Use of Blood Thinners**	☐ **Fractures**	☐ **Osteoporosis**
☐ **Bowel or Bladder Disorder**	☐ **Headaches**	☐ **Pacemaker**
☐ **Bleeding Disorder**	☐ **Head Injury or Concussion**	☐ **Parkinson's Disease**
☐ **Cancer**	☐ **Hearing Impairment**	☐ **Peripheral Vascular Disease**
☐ **Chronic Cough**	☐ **Heart Disease or Heart Attack**	☐ **Respiratory or Breathing Problems**
☐ **COPD**	☐ **Hepatitis** ☐ **A** ☐ **B** ☐ **C**	☐ **Ringing in Ears**
☐ **Congestive Heart Failure**	☐ **Hernia**	☐ **Sexual Dysfunction**
☐ **Currently Pregnant**	☐ **Blood Pressure** ☐ **High** ☐ **Low**	☐ **Skin Abnormalities**
☐ **Deep Vein Thrombosis (DVT)**	☐ **HIV or AIDS**	☐ **Stroke or TIA**
☐ **Depression**	☐ **Hypoglycemia**	☐ **Thyroid Problems**
☐ **Diabetes** ☐**Type I** ☐ **Type II**	☐ **Hypersensitivity to Hot or Cold**	☐ **Tuberculosis**

List any other medical problems and explain:

Patient History

Patient Name: _____ Today's date: _____ Date of injury/onset: _____

Referring Physician_____ Primary Care Physician _____

History of Present Condition:

1. Chief Complaint (Why are you seeing us today?) _____
2. How long have you had this problem? (Date Specific) _____
3. What started this problem? _____
4. Has the problem become worse? ☐ YES ☐ NO If Yes, Date_____
5. Is the problem a result of a car accident? ☐ YES ☐ NO If Yes, Date_____
6. Is the problem a result of a work accident? ☐ YES ☐ NO If Yes, Date_____
7. Is the problem a result of a fall? ☐ YES ☐ NO If Yes, Date_____

Rate your CURRENT pain severity using the following scale: *(Check a number)*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Rate your pain severity AT WORST using the following scale: *(Check a number)*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe the quality of your pain? (*Check All That Apply)*

☐Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Aching
☐ Dull ☐ Throbbing ☐ Continuous ☐ Intermittent ☐ Other_____

What makes your problem worse? _____

Does anything make your problem better? ☐ YES ☐ NO
If yes, please list: _____

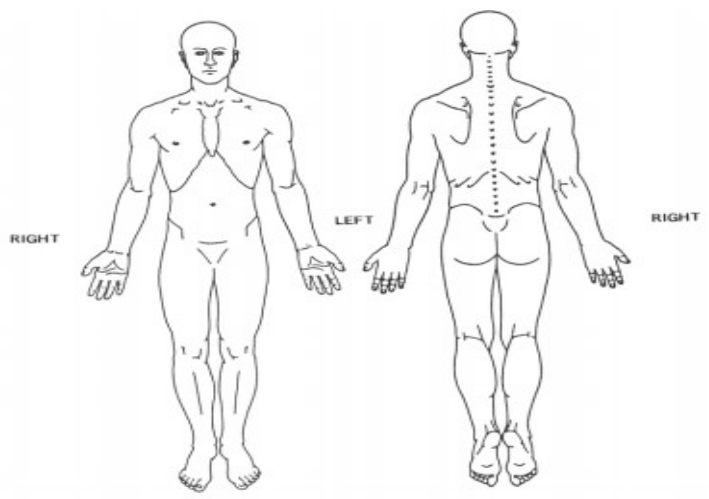
Treatments for your chief complaint have included: *(Check all that apply)*

☐ Physical Therapy	☐ NSAID Medication
☐ Occupational Therapy	☐ Ice/Heat
☐ Massage Therapy	☐ Pain Medication
☐ Chiropractic Treatments	☐ Other:_____

Please use the diagram to the right to indicate:

OOO = Pain

XXX = Numbness



Have you had Physical or Occupational Therapy this calendar year? ☐ YES ☐ NO
If yes, where did you receive your therapy? ☐ Hospital ☐ Home Health ☐ Outpatient Facility ☐ Other
Please list: _____

Test	Area Tested	Date	Testing Company
X-Rays			
MRI			
Other Test: _____			

Medical History (*Check all that apply)*

☐ Abnormal Bleeding	☐ Chronic Back Pain	☐ Diabetes Type II	☐ High Cholesterol	☐ Osteoarthritis
☐ Angina	☐ Chronic Neck Pain	☐ DVT	☐ HIV/AIDS	☐ Osteoporosis
☐ Anxiety	☐ Closed Head Injury	☐ Fibromyalgia	☐ Hypertension	☐ Psoriatic Arthritis
☐ Arrhythmia	☐ Colitis	☐ Frequent UTI	☐ Hypothyroidism	☐ PVD
☐ Asthma	☐ CHF	☐ GERD	☐ IBS	☐ RA
☐ Bipolar Disorder	☐ COPD	☐ Glaucoma	☐ Joint Pain	☐ Scoliosis
☐ Blood Clotting	☐ Crohn's Disease	☐ Gout	☐ Lymphedema	☐ Seizure Disorder
☐ Bowel Incontinence	☐ CVA (Stroke)	☐ Heart Disease	☐ Migraine Headaches	☐ Shortness of Breath
☐ Cancer	☐ Degen. Disc Disease	☐ Hepatitis B	☐MRSA	☐ Sleeping Disorder
☐ Carpal Tunnel	☐ Depression	☐ Hepatitis C	☐ Multiple Sclerosis	☐ TB (Tuberculosis)
☐ Cellulitis	☐ Diabetes Type I	☐ Hiatal Hernia	☐Heart Attack	☐ Incontinence

Describe any other conditions or precautions not listed above:_____
Do you have a pacemaker: ☐ **YES** ☐ **NO**
Are you currently pregnant: ☐ **YES** ☐ **NO**

Surgical History:

Body Region:	Surgery Type:	Date:
Body Region:	Surgery Type:	Date:
Body Region:	Surgery Type:	Date:

Current Medications: ☐ ***I have provided a list of medications to the front desk.***

Drug Name:	Dosage:	Reason for Taking:
Drug Name:	Dosage:	Reason for Taking:
Drug Name:	Dosage:	Reason for Taking:

Work Status: ☐ Part time Student ☐ Full time Student ☐ Employed
Marital Status: ☐ Single ☐ Married ☐ Other

My Signature confirms I have answered the above questions to the best of my ability.

Patient Signature: _____ Date _____
(Parent/Guardian if under 18 years old)

Therapist Signature: _____ Date _____